Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003984	A. BUILDING: _____ B. WING _____	07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON PLACE	**10799 ALLIANCE DR CAMBY, IN 46113**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a Quality Assurance Walk Through Survey. Survey date: July 22, 2014 Facility number: 3984 Provider number: 3984 AIM number: N/A Survey team: Diana Zgonc, RN-TC Census bed type: Residential: 34 Total: 34 Census payor type: Other: 34 Total: 34 Sample: N/A Worthington Place was found to be in compliance with 410 IAC 16.2 in regard to a Quality Assurance Walk Through Survey. Quality Review 07/23/14 by Lisa McColly	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE